RENEWAL APPLICATION FORM
Registration for the Montana Medical Marijuana Program

Instructions: **Please complete all information to comply with the registration requirements of the Montana Medical Marijuana Act.** If applicant is a minor (under 18), the custodial parent or legal guardian with responsibility for health care decisions must be listed as the Primary Caregiver and the information requested on the back of this form must be completed. List your current Montana Drivers License number **or** your Montana State Identification Card number if applicable **and** your Social Security Number. Please type or print legibly.

QUALIFYING PATIENT INFORMANTION (REQUIRED)

NAME (LAST, FIRST, M.I.): _____ MALE___ FEMALE____

DATE OF BIRTH: _____ MT DRIVERS LICENSE OR MT STATE ID #_____ SSN_____

MAILING ADDRESS: _____ COUNTY_____ PHONE #_____

CITY: _____ STATE_____ ZIP CODE_____ EMAIL ADDRESS_____
(OPTIONAL)

CAREGIVER *(IF APPLICABLE)*

NAME (LAST, FIRST, M.I.): _____ MALE____ FEMALE____

DATE OF BIRTH: _____ MT DRIVERS LICENSE OR MT STATE ID #_____ SSN_____

MAILING ADDRESS:_____ COUNTY_____ PHONE #_____

CITY: _____ STATE_____ ZIP CODE_____ EMAIL ADDRESS_____
(OPTIONAL)

NEW REGISTRATION FEE *(REQUIRED)*

The renewal fee is $50.00 and is non refundable unless the applicant is denied.

Enclose your check or money order made payable to "DPHHS /LICENSURE BUREAU

SIGNATURE & DATE REQUIRED

QUALIFYING PATIENT SIGNATURE: _____ DATE: _____

"QUALIFYING PATIENT" Means a person who has been diagnosed by a physician as having a Debilitating Medical Condition.

CAREGIVER SIGNATURE: _____ DATE: _____

As the CAREGIVER for the Qualifying Patient named above, I agree to provide Medical Marijuana only to this Qualifying Patient. I have never been convicted of a felony drug offense. I understand that I am subject to a mandatory background check.

(OVER)

DECLARATION OF PERSON RESPONSIBLE FOR MINOR

INSTRUCTIONS: Complete all information in order to comply with the registration requirements of the Montana Medical Marijuana Act. This portion is required in addition to the patient application portion if the qualifying patient is under 18 years of age.

1. I am the __Custodial Parent or __Legal Guardian with responsibility for health care decisions for:

_____
MINORS NAME

2. The applicant's attending physician has explained to the minor and me the potential risk and benefits of the medical use of marijuana.
3. I consent to the use of marijuana by the applicant for medical purposes.
4. I agree to serve as minor's designated primary caregiver; AND
5. I agree to control the acquisition of marijuana and the dosage and frequency of use by the minor.

NAME (LAST, FIRST, M.I.): _____MALE_____FEMALE_____

DATE OF BIRTH: _____MT DRIVERS LICENSE OR STATE ID #_____SSN_____

MAILING ADDRESS: _____TELEPHONE NUMBER_____

CITY: _____STATE_____ZIP CODE_____EMAIL ADDRESS_____
(optional)

SIGNATURE OF CUSTODIAL PARENT OR LEGAL GUARDIAN: _____

MAIL APPLICATION FORM TO: DPHHS / QUALITY ASSURANCE DIVISION
LICENSURE BUREAU
PO BOX 202953
HELENA MT 59620-2953